

		FOR OHF USE					

LL 1

**2003**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF PUBLIC AID**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2003)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION  
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY  
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE  
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE  
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL  
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM  
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<b>I. IDPH Facility ID Number:</b> <u>8008518</u>		<b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b>	
<b>Facility Name:</b> <u>Gottlieb Memorial Hospital</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/03</u> to <u>12/31/03</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
<b>Address:</b> <u>701 West North Avenue</u> <u>Melrose Park</u> <u>60160</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
<b>County:</b> <u>Cook</u>		<b>Officer or Administrator of Provider</b> (Signed) _____ (Date) _____ (Type or Print Name) <u>Andrew Knauf</u> (Title) <u>Vice President, Finance</u>	
<b>Telephone Number:</b> <u>708-450-4949</u> <b>Fax #</b> <u>708-681-1688</u>		<b>Paid Preparer</b> (Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>( )</u> <b>Fax #</b> ( )	
<b>IDPA ID Number:</b> _____		<b>MAIL TO: OFFICE OF HEALTH FINANCE</b> <b>ILLINOIS DEPARTMENT OF PUBLIC AID</b> <b>201 S. Grand Avenue East</b> <b>Springfield, IL 62763-0001</b> <b>Phone # (217) 782-1630</b>	
<b>Date of Initial License for Current Owners:</b> <u>06/10/85</u>			
<b>Type of Ownership:</b>			
<input checked="" type="checkbox"/> <b>VOLUNTARY, NON-PROFIT</b>			
<input checked="" type="checkbox"/> Charitable Corp.			
<input type="checkbox"/> Trust			
<b>IRS Exemption Code</b> _____			
<input type="checkbox"/> <b>PROPRIETARY</b>			
<input type="checkbox"/> Individual			
<input type="checkbox"/> Partnership			
<input type="checkbox"/> Corporation			
<input type="checkbox"/> "Sub-S" Corp.			
<input type="checkbox"/> Limited Liability Co.			
<input type="checkbox"/> Trust			
<input type="checkbox"/> Other _____			
<b>In the event there are further questions about this report, please contact:</b> <b>Name:</b> <u>Ellyn Chin</u> <b>Telephone Number:</b> <u>708-450-4534</u>			

## STATE OF ILLINOIS

Page 2

Facility Name & ID Number Gottlieb Memorial Hospital# 8008518 Report Period Beginning: 01/01/03 Ending: 12/31/03

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed beds \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>34</u>	Skilled (SNF)	<u>34</u>	<u>12,410</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>34</u>	TOTALS	<u>34</u>	<u>12,410</u>	7

## B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>450</u>		<u>9,041</u>	<u>9,491</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>450</u>		<u>9,041</u>	<u>9,491</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 76.48%

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)NoneF. Does the facility maintain a daily midnight census? YesG. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 05/20/85

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date \_\_\_\_\_ NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number  
of beds certified 34 and days of care provided 8,257Medicare Intermediary Administar Federal

## IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH\* ☐ CASH\* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/03 Fiscal Year: 12/31/03

\* All facilities other than governmental must report on the accrual basis.

## STATE OF ILLINOIS

Page 3

Facility Name & ID Number      **Gottlieb Memorial Hospital**#      **8008518**Report Period Beginning:      **01/01/03**Ending:      **12/31/03****V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>A. General Services</b>											
1	Dietary	129,539	19,175	76,458	225,172		225,172		225,172			1
2	Food Purchase		41,253		41,253		41,253		41,253			2
3	Housekeeping	83,570	13,897	45,380	142,847		142,847		142,847			3
4	Laundry	9,733	13,751	29,160	52,644		52,644		52,644			4
5	Heat and Other Utilities			135,170	135,170		135,170		135,170			5
6	Maintenance	83,631	10,196	25,047	118,874		118,874		118,874			6
7	Other (specify):* Cafeteria	3,262	17	6,857	10,136		10,136		10,136			7
8	<b>TOTAL General Services</b>	309,735	98,289	318,072	726,096		726,096		726,096			8
	<b>B. Health Care and Programs</b>											
9	Medical Director											9
10	Nursing and Medical Records	1,776,039	76,308	91,625	1,943,972		1,943,972		1,943,972			10
10a	Therapy	60,717	194	318	61,229		61,229		61,229			10a
11	Activities											11
12	Social Services											12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	<b>TOTAL Health Care and Programs</b>	1,836,756	76,502	91,943	2,005,201		2,005,201		2,005,201			16
	<b>C. General Administration</b>											
17	Administrative	78,469	1,455	69,288	149,212		149,212		149,212			17
18	Directors Fees											18
19	Professional Services											19
20	Dues, Fees, Subscriptions & Promotions											20
21	Clerical & General Office Expenses											21
22	Employee Benefits & Payroll Taxes			379,957	379,957		379,957		379,957			22
23	Inservice Training & Education											23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			36,894	36,894		36,894		36,894			26
27	Other (specify):*											27
28	<b>TOTAL General Administration</b>	78,469	1,455	486,139	566,063		566,063		566,063			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,224,960	176,246	896,154	3,297,360		3,297,360		3,297,360			29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

## STATE OF ILLINOIS

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Facility Name & ID Number Gottlieb Memorial Hospital

#8008518

Report Period Beginning:

01/01/03

Ending:

12/31/03

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			260,513	260,513		260,513		260,513			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			14,311	14,311		14,311		14,311			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			274,824	274,824		274,824		274,824			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			1,912,855	1,912,855		1,912,855		1,912,855			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee											42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			1,912,855	1,912,855		1,912,855		1,912,855			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,224,960	176,246	3,083,833	5,485,039		5,485,039		5,485,039			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number **Gottlieb Memorial Hospital**# **8008518**Report Period Beginning: **01/01/03**Ending: **12/31/03****VI. ADJUSTMENT DETAIL****A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.****In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer-</b>	<b>OHF USE</b>	
			<b>ence</b>	<b>ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$		\$	30

<b>OHF USE ONLY</b>						
48		49	50	51	52	

**B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)**

		1	2	
		<b>Amount</b>	<b>Reference</b>	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	<b>(sum of SUBTOTALS</b>			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

**C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)**

		1	2	3	4	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

Gottlieb Memorial Hospital

ID# 8008518

Report Period Beginning: 01/01/03

Ending: 12/31/03

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

## Summary A

12/31/03

12/31/03

[illegible]

## Summary B

12/31/03

## 12/31/03

[illegible]



VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
			Item		Name of Related Organization				
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 Report Period Beginning: 01/01/03 Ending: 12/31/03

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).  
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,  
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Gottlieb Memorial Hospital# 8008518

Report Period Beginning:

01/01/03Ending: 12/31/03

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	<u>Dietary</u>	<u>Meals Served</u>	<u>137,226</u>		<u>\$ 1,298,511</u>	<u>\$ 747,019</u>	<u>23,796</u>	<u>\$ 225,171</u>	1
2	<u>Food Purchase</u>	<u>Meals Served</u>	<u>137,226</u>		<u>237,897</u>	<u>0</u>	<u>23,796</u>	<u>41,253</u>	2
3	<u>Housekeeping</u>	<u>Time Spent</u>	<u>26,693</u>		<u>1,702,229</u>	<u>995,858</u>	<u>2,240</u>	<u>142,846</u>	3
4	<u>Laundry</u>	<u>Pounds of Laundry</u>	<u>534,034</u>		<u>511,169</u>	<u>94,507</u>	<u>54,999</u>	<u>52,644</u>	4
5	<u>Heat/Utilities</u>	<u>Square Feet</u>	<u>201,683</u>		<u>2,230,894</u>	<u>0</u>	<u>12,220</u>	<u>135,170</u>	5
6	<u>Plant</u>	<u>Square Feet</u>	<u>201,683</u>		<u>1,082,457</u>	<u>840,425</u>	<u>12,220</u>	<u>65,586</u>	6
7	<u>Cafeteria</u>	<u>FTEs Served</u>	<u>25,822</u>		<u>262,873</u>	<u>84,600</u>	<u>996</u>	<u>10,137</u>	7
8	<u>Nursing</u>	<u>Direct RN Hours</u>	<u>42,827</u>		<u>1,436,276</u>	<u>1,314,127</u>	<u>3,527</u>	<u>118,284</u>	8
9	<u>Medical Records</u>	<u>Time Spent</u>	<u>5,762</u>		<u>1,270,661</u>	<u>1,192,671</u>	<u>296</u>	<u>65,275</u>	9
10	<u>Social Services</u>	<u>Time Spent</u>	<u>8,708</u>		<u>297,862</u>	<u>295,375</u>	<u>1,790</u>	<u>61,228</u>	10
11	<u>Administration</u>	<u>Revenue</u>	<u>450,712,037</u>		<u>13,766,273</u>	<u>7,239,538</u>	<u>4,885,228</u>	<u>149,211</u>	11
12	<u>Employee Benefits</u>	<u>Gross Salaries</u>	<u>48,253,151</u>		<u>11,213,250</u>	<u>0</u>	<u>1,635,043</u>	<u>379,957</u>	12
13	<u>Property Insurance</u>	<u>Square Feet</u>	<u>201,683</u>		<u>76,771</u>	<u>0</u>	<u>12,220</u>	<u>4,652</u>	13
14	<u>Maintenance</u>	<u>Time Spent</u>	<u>56,430</u>		<u>1,093,482</u>	<u>671,219</u>	<u>2,750</u>	<u>53,289</u>	14
15	<u>Malpractice Insurance</u>	<u>Revenue</u>	<u>450,712,037</u>		<u>2,545,520</u>	<u>0</u>	<u>4,885,228</u>	<u>27,591</u>	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	<b>TOTALS</b>				<b>\$ 39,026,125</b>	<b>\$ 13,475,339</b>		<b>\$ 1,532,294</b>	25

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

**A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	IHFA		X	Refinance & Equipment	Interest	1990	\$ 27,209,221	\$ 24,828,381	11/15/25	Floating	\$ 2,826	1	
2	IHFA		X	Refinance & Equipment	Interest	1994	12,477,021	12,000,000	11/15/24	Floating	1,356	2	
3	IHFA		X	Refinance & Equipment	Interest	1999	28,900,000	25,913,770		Floating	2,994	3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 68,586,242	\$ 62,742,151			\$ 7,176	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 68,586,242	\$ 62,742,151			\$ 7,176	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ \_\_\_\_\_ Line # \_\_\_\_\_

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

**Important**, please see the next worksheet, "RE\_Tax". The real estate tax statement and bill must accompany the cost report.

Real Estate Tax History:		FOR OHF USE ONLY	
1. Real Estate Tax accrual used on 2002 report.	\$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$		2
3. Under or (over) accrual (line 2 minus line 1).	\$		3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	\$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$		7
Real Estate Tax Bill for Calendar Year:			
1998	8		
1999	9		
2000	10		
2001	11		
2002	12		
		13	FROM R. E. TAX STATEMENT FOR 2002 \$
		14	PLUS APPEAL COST FROM LINE 5 \$
		15	LESS REFUND FROM LINE 6 \$
		16	AMOUNT TO USE FOR RATE CALCULATION \$

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. **This denial must be no more than four years old at the time the cost report is filed.**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates    **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

**2002 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME    Gottlieb Memorial Hospital    COUNTY    Cook

FACILITY IDPH LICENSE NUMBER    8008518

CONTACT PERSON REGARDING THIS REPORT    \_\_\_\_\_

TELEPHONE (    )    FAX #: (    )

**A.    Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	_____	_____	\$ _____	\$ _____
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		<b>TOTALS</b>	<b>\$ _____</b>	<b>\$ _____</b>

**B.    Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?    \_\_\_\_\_ YES    \_\_\_\_\_ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home.  
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C.    Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

A. Square Feet:
 

12,220

B. General Construction Type:
 

Exterior
 

Concrete

Frame
 

Reinforced Concrete

Number of Stories
 

6

C. Does the Operating Entity?
 

X

(a) Own the Facility

(b) Rent from a Related Organization.

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?
 

X

(a) Own the Equipment

(b) Rent equipment from a Related Organization.

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

YES

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:
 
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Hospital & Parking	1,458,000	1961	\$ 61,937	1
2					2
3	TOTALS	1,458,000		\$ 61,937	3

Facility Name & ID Number    Gottlieb Memorial Hospital#    8008518

Report Period Beginning:

01/01/03

Ending:

12/31/03**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1961	1961	\$ 1,789,885	\$ 35,798	50	\$ 35,798		\$ 1,521,406	4
5			1982	1982	1,135,357	39,150	29	39,150		841,728	5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	Building Improvements		1961		927,147		25			927,147	9
10	Building Improvements		1962		5,314	108	49	108		4,434	10
11	Building Improvements		1963		57,578	1,152	47-50	1,152		46,651	11
12	Building Improvements		1964		154	3	46	3		124	12
13	Building Improvements		1965		839,469	9,188	25-50	9,188		733,807	13
14	Building Improvements		1966		18,069	181	20-45	181		16,613	14
15	Building Improvements		1967		99,677	1,123	25-44	1,123		91,261	15
16	Building Improvements		1969		243,126	3,854	10-42	3,854		214,571	16
17	Building Improvements		1970		10,866		15-25			10,866	17
18	Building Improvements		1971		410,569	4,156	20-40	4,156		379,677	18
19	Building Improvements		1972		63,023	286	10-39	286		60,997	19
20	Building Improvements		1973		36,443		15-20			36,443	20
21	Building Improvements		1974		70,028	1,796	15-37	1,796		56,503	21
22	Building Improvements		1975		2,422		10			2,422	22
23	Building Improvements		1976		3,446,023	48,351	5-36	48,351		3,083,332	23
24	Building Improvements		1977		7,474,834	97,201	5-35	97,201		6,648,650	24
25	Building Improvements		1978		172,682	1,729	5-35	1,729		162,564	25
26	Building Improvements		1979		159,159	1,234	5-34	1,234		149,674	26
27	Building Improvements		1980		729,897	14,979	8-31	14,979		617,559	27
28	Building Improvements		1981		1,633,608	33,354	10-11	33,354		1,475,461	28
29	Building Improvements		1982		3,024,034	18,356	6-20	18,356		2,886,368	29
30	Building Improvements		1983		3,028,019	99,370	5-28	99,370		2,373,751	30
31	Building Improvements		1984		245,719	9,407	5-20	9,407		239,022	31
32	Building Improvements		1985		7,212,994	242,300	5-40	242,300		5,527,701	32
33	Building Improvements		1986		2,251,370	99,374	5-20	99,374		2,009,341	33
34	Building Improvements		1987		1,228,658	44,030	5-40	44,030		1,025,169	34
35	Building Improvements		1988		1,055,957	44,751	10-20	44,751		844,248	35
36	Building Improvements		1989		5,888,073	282,247	5-25	282,247		4,309,884	36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total



**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Building Improvements	1990	\$ 5,443,853	\$ 269,266	5-20	\$ 269,266	\$	\$ 3,577,834		37
38	Building Improvements	1991	2,702,153	134,804	10-20	134,804		1,648,131		38
39	Building Improvements	1992	2,395,627	119,128	2-20	119,128		1,377,740		39
40	Building Improvements	1993	1,601,815	79,039	2-20	79,039		837,607		40
41	Building Improvements	1994	2,933,037	146,653	20	146,653		1,396,243		41
42	Building Improvements	1995	4,798,468	236,753	20	236,753		2,023,544		42
43	Co-Generator Construction	1996	1,524,624	76,231	20	76,231		594,025		43
44	Emergency Water Main	1996	28,313	1,416	20	1,416		10,340		44
45	Absorption Chiller Construction	1996	558,317	27,916	20	27,916		214,788		45
46	Architecture Fees	1996	591,268	29,563	20	29,563		221,168		46
47	Hospital Signage	1996	9,074	454	20	454		3,497		47
48	Install Backflow Preventers	1996	23,735	1,187	20	1,187		9,122		48
49	Plumbing	1996	1,133	57	20	57		444		49
50	Remove Fiber Optics	1996	6,184	309	20	309		2,396		50
51	Emergency Power for Elevators	1996	7,800	390	20	390		2,990		51
52	POB Improvements	1996	467,262	23,363	20	23,363		178,581		52
53	Heating Work	1996	1,220	61	20	61		432		53
54	Construction Hospital Entrance	1996	118,241	5,912	20	5,912		42,129		54
55	Lightening Protection	1996	9,912	496	20	496		3,965		55
56	Remodeling Home Health	1996	39,853	1,993	20	1,993		15,357		56
57	Miscellaneous Improvements	1996	52,594	2,630	20	2,630		20,215		57
58	Warehouse	1996	25	1	20	1		9		58
59	Remodel Radiology	1996	2,052	103	20	103		795		59
60	Remodel Same Day Surgery	1996	30,902	1,545	20	1,545		11,227		60
61	Remodel ICU	1996	1,660	83	20	83		636		61
62	Remodel West Wing	1996	29,250	1,463	20	1,463		10,678		62
63	Remodel Medical Staff Office	1996	2,822	141	20	141		1,101		63
64	Slope Sink - Mechanical	1996	2,168	108	20	108		849		64
65	Remodel South Wing	1996	185,279	9,264	20	9,264		73,373		65
66	Remodel Operating Room	1996	25,040	1,252	20	1,252		9,227		66
67	Remodel Audiology	1996	1,500	75	20	75		600		67
68	Carpeting	1996	2,073	104	20	104		813		68
69	Cath Lab/Angio Addition	1996	600,588	30,029	20	30,029		217,311		69
70	TOTAL (lines 4 thru 69)		\$ 67,457,995	\$ 2,335,266		\$ 2,335,266	\$	\$ 48,804,543		70

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

12/31/03

**\*\*Improvement type must be detailed in order for the cost report to be considered complete.**

12/31/03

**\*\*Improvement type must be detailed in order for the cost report to be considered complete.**

**\*\*Improvement type must be detailed in order for the cost report to be considered complete.**

12/31/03

**\*\*Improvement type must be detailed in order for the cost report to be considered complete.**

**XI. OWNERSHIP COSTS (continued)**

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 96,950,054	\$ 3,814,062		\$ 3,814,062		\$ 54,889,332	1
2	Construction Hospital Entrance	2002	562	28	20	28		35	2
3	Remodel Cath Lab	2002	157,692	7,937	20	7,937		9,894	3
4	Remodel Cafeteria	2002	24,618	1,231	20	1,231		2,462	4
5	Miscellaneous Improvements	2003	2,622	197	20	197		197	5
6	Remodel Surgery	2003	261,619	710	20	710		710	6
7	Remodel Emergency Room	2003	12,328	467	20	467		467	7
8	Remodel West Wing	2003	12,362	616	20	616		616	8
9	POB Improvements	2003	194,747	6,789	20	6,789		6,789	9
10	Emergency Generator	2003	182,120	6,969	20	6,969		6,969	10
11	Remodel MRI	2003	112,180	2,111	20	2,111		2,111	11
12	Remodel Medical Staff Office	2003	16,083	662	20	662		662	12
13	HVAC Improvements	2003	20,500	1,025	20	1,025		1,025	13
14	Remodel Cath Lab	2003	800,446	28,611	20	28,611		28,611	14
15	Land Improvements Total Hospital		4,479,117	86,694	5-25	86,694		3,945,246	15
16									16
17									17
18	Less allocations to other hospital areas								18
19	based upon square footage (6.29% to TCU)		(96,734,069)	(3,709,247)		(3,709,247)		(55,190,622)	19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,492,982	\$ 248,861		\$ 248,861		\$ 3,704,503	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**C. Equipment Depreciation-Excluding Transportation. (See instructions.)**

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 61,642	\$ 10,462	\$ 10,462	\$	3-11	\$ 31,739	71
72	Current Year Purchases	9,340	394	394		5-15	394	72
73	Fully Depreciated Assets	9,217	796	796		5	9,217	73
74								74
75	TOTALS	\$ 80,199	\$ 11,652	\$ 11,652	\$		\$ 41,350	75

**D. Vehicle Depreciation (See instructions.)\***

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

**E. Summary of Care-Related Assets**

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 6,635,117	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 260,513	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 260,513	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,745,853	85

**F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)**

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

**G. Construction-in-Progress**

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

## XII. RENTAL COSTS

### A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: \_\_\_\_\_

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? \_\_\_\_\_

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized  
by the length of the lease \_\_\_\_\_.

9. Option to Buy: ☐ YES ☐ NO Terms: \_\_\_\_\_ \*

### B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? \_\_\_\_\_

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ \_\_\_\_\_ Description: \_\_\_\_\_

(Attach a schedule detailing the breakdown of movable equipment)

### C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. 2004 \$ \_\_\_\_\_

13. 2005 \$ \_\_\_\_\_

14. 2006 \$ \_\_\_\_\_

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.



**A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)**

<b>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</b>  <input type="checkbox"/> YES <input type="checkbox"/> NO  If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	<b>2. CLASSROOM PORTION:</b>  IN-HOUSE PROGRAM <input type="checkbox"/>  IN OTHER FACILITY <input type="checkbox"/>  COMMUNITY COLLEGE <input type="checkbox"/>  HOURS PER AIDE _____	<b>3. CLINICAL PORTION:</b>  IN-HOUSE PROGRAM <input type="checkbox"/>  IN OTHER FACILITY <input type="checkbox"/>  HOURS PER AIDE _____
--	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		1		2		3	4
		Facility					
		Drop-outs	Completed	Contract	Total		
1	Community College Tuition	\$	\$	\$	\$		
2	Books and Supplies						
3	Classroom Wages (a)						
4	Clinical Wages (b)						
5	In-House Trainer Wages (c)						
6	Transportation						
7	Contractual Payments						
8	Nurse Aide Competency Tests						
9	TOTALS	\$	\$	\$	\$		
10	SUM OF line 9, col. 1 and 2 (e)	\$					

**C. CONTRACTUAL INCOME**

In the box below record the amount of income your facility received training aides from other facilities.

\$ \_\_\_\_\_

**D. NUMBER OF AIDES TRAINED**

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.  
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.  
 (c) For in-house training programs only. Do not include fringe benefits.  
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.  
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
					1	Licensed Occupational Therapist		hrs	\$		
2	Licensed Speech and Language Development Therapist		hrs								2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist		hrs								4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy		# of prescrpts								9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify):										13
14	TOTAL			\$		\$	\$		\$		14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 22,814,425	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 1,907,813 )	14,831,156		3
4	Supply Inventory (priced at cost )	2,300,146		4
5	Short-Term Investments	21,582,270		5
6	Prepaid Insurance	628,123		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due from Affiliates	2,408,250		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 64,564,370	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	89,452,350		12
13	Land	4,293,071		13
14	Buildings, at Historical Cost	103,227,050		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	38,402,587		16
17	Accumulated Depreciation (book methods)	(86,154,076)		17
18	Deferred Charges	7,397,986		18
19	Organization & Pre-Operating Costs			19
	Accumulated Amortization -			
20	Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe Inv in PHO,Self Ins	2,097,774		22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 158,716,742	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 223,281,112	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 3,254,102	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	6,321,523		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	Accrued Exp/Bond Payable	2,904,004		36
37	Third Party Settlement	11,901,584		37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 24,381,213	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	61,519,304		41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	Reserve for Self Insurance	13,496,204		43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 75,015,508	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 99,396,721	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 123,884,391	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 223,281,112	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>115,967,430</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>115,967,430</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>7,074,009</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe) <b>Forgiven Amt due to GHR &amp; GHS</b>	<b>842,952</b>	<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>7,916,961</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>123,884,391</b>	<b>24 *</b>

\* This must agree with page 17, line 47.

**VII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.  
**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 450,712,037	1
2	Discounts and Allowances for all Levels	(334,317,879)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 116,394,158	3
	<b>B. Ancillary Revenue</b>		
4	Day Care	392,362	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 392,362	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	53,307	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	360,493	14
15	Telephone, Television and Radio	9,606	15
16	Rental of Facility Space	205,718	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	1,198,227	19
20	Radiology and X-Ray	16,271	20
21	Other Medical Services	129,543	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 1,973,165	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions	450,797	24
25	Interest and Other Investment Income***	2,698,756	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 3,149,553	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Misc Non Operating Revenue</b>	(28,264)	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ (28,264)	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 121,880,975	30

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	114,806,966	31
32	Health Care		32
33	General Administration		33
	<b>B. Capital Expense</b>		
34	Ownership		34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers		35
36	Provider Participation Fee		36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 114,806,966	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	7,074,009	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 7,074,009	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? \_\_\_\_\_ If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Gottlieb Memorial Hospital# 8008518Report Period Beginning: 01/01/03Ending: 12/31/03

12/31/03

## XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,916	2,164	\$ 77,173	\$ 35.66	1
2	Assistant Director of Nursing					2
3	Registered Nurses	28,338	31,633	935,068	29.56	3
4	Licensed Practical Nurses	5,797	6,620	122,189	18.46	4
5	Nurse Aides & Orderlies	26,044	29,179	326,239	11.18	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,900	2,079	28,975	13.94	9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers					18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	2,032	2,313	46,315	20.02	22
23	Office Manager					23
24	Clerical	4,733	5,666	68,752	12.13	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	70,760	79,654	\$ 1,604,711 *	\$ 20.15	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

## B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$		49

## C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	433	\$ 30,333		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	433	\$ 30,333		53

Facility Name &amp; ID Number      Gottlieb Memorial Hospital

# 8008518

Report Period Beginning: 01/01/03

**Ending:** 12/31/03

## **XIX. SUPPORT SCHEDULES**

[illegible]

\* Attach copy of IMRF notifications

**\*\*See instructions.**

[illegible]



**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN, LPN, NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No  
If YES, give association name and amount. \_\_\_\_\_
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 5
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line \_\_\_\_\_
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation. \_\_\_\_\_
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. \_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 0  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation. \_\_\_\_\_
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 10,137 Has any meal income been offset against related costs? No Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? \_\_\_\_\_  
d. Have vehicle usage logs been maintained? \_\_\_\_\_  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? \_\_\_\_\_  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? \_\_\_\_\_  
**g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? \_\_\_\_\_  
Firm Name: Ernst & Young The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Not available at this time
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.